

MOTOR VEHICLE ACCIDENT QUESTIONNAIRE

NAME:

Our Reference:

| | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------|---------------|------------------------------------------------------------------------------|----|
| 1. Date of Accident : | | 2. Time of Accident: <input type="checkbox"/> AM <input type="checkbox"/> PM | |
| 3. Location of Accident: | | | |
| 4. How many vehicles were involved, including the vehicle you occupied? | | | |
| 5. Were you the driver of the vehicle? | | | |
| 6. Were you driving while under the influence of alcohol or drugs at the time of accident? | | | |
| 7. Total Cost of Damage to your Vehicle including year/model: | | | |
| 8. Total Cost of Damage to other Vehicle if applicable, including year/model: | | | |
| 9. Please describe how accident happened: | | | |
| 10. Please provide all information pertaining to your insurance carriers: (including Auto, Group Health & Group Life Insurance companies): | | | |
| Name of Insurance Company: | Policy Number | Contact Name/Phone Number | |
| | | | |
| | | | |
| | | | |
| 11. Were there any charges laid? | | Yes | No |
| If yes – which party was charged? | | | |
| What were the charges laid? | | | |
| Is a copy of the Police Report available? If so, please provide a copy. | | | |
| Please provide any additional details you feel would assist in the review of your file: | | | |



Creditor Insurance Office-Toronto
330 University Avenue
Toronto ON M5G 1R8

Fax No.: 416-552-6557

By signing below, you acknowledge & understand that the answers on this questionnaire are true & complete. You authorize the Insurer to obtain, provide and exchange such personal information as may be required for the adjudication of your claim. You understand concealment, misrepresentation or false declaration concerning this questionnaire could jeopardize your claim.

| | |
|-------|------------|
| Date: | Signature: |
|-------|------------|